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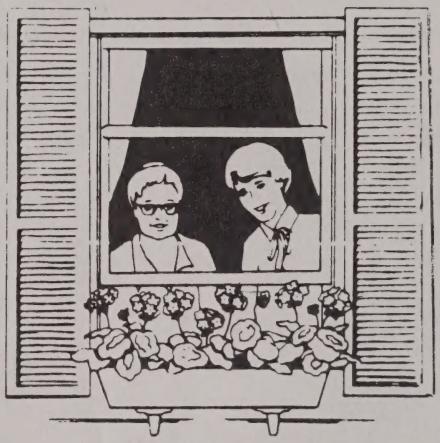

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A Message from Carol Nystrom:

Every HDMS member I have met has one outstanding quality — friendliness, and I thank you for making me feel welcome.

Time and time again busy physicians have taken huge chunks out of their busy schedules to work with me and offer their help and expertise. I am grateful to all of you and will do my best to continue the high quality of work that Vivian Purdy provided for so many years.

Vivian handled the Executive Secretary's job with seemingly effortless ease and skill. During the years I worked at Municipal Hospital and the Springfield Health Department I watched Vivi breeze by with a friendly wave, off to another meeting, and marveled at her stamina.

Being your Executive Secretary means accepting new levels of work for me and each day offers a different problem and challenge. I thank you for this marvelous opportunity.

Carol DiClementi and I look forward to helping you, so please call us. □

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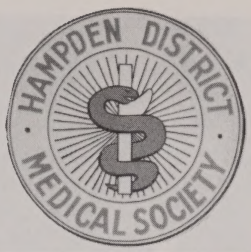

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THE HAMPDEN HIPPOCRAT IS PUBLISHED MONTHLY EXCEPT FOR JULY AND AUGUST.

THE OPINIONS EXPRESSED IN THIS BULLETIN ARE THOSE OF THE WRITERS AND DO NOT REFLECT THE OFFICIAL VIEWPOINT OF THE HAMPDEN DISTRICT MEDICAL SOCIETY UNLESS SO STATED.

ALL COMMUNICATIONS SHOULD BE ADDRESSED TO CAROL L. NYSTROM, HAMPDEN DISTRICT MEDICAL SOCIETY, 1414 STATE ST., SPRINGFIELD, MASS. 01109: TELEPHONE: 736-0661.

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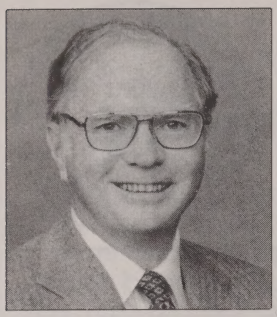

PRESIDENT'S PAGE

Wedges

Terry D. Ryan, M.D.
President

American Medicine is one of the few medical systems in the industrialized world that has by and large escaped "government medicine"; but in the process are we fleeing into the grasp of "corporate medicine"? The rapid changes we see occurring may be put in a somewhat better perspective, if we listen to how a student from outside the profession perceives it. The following is a pertinent excerpt from *The Social Transformation of American Medicine* by Paul Starr.*

"The independent small businessman is firmly rooted in the American imagination. His misfortune is that he is much less firmly rooted in the American economy. As large corporations have risen to dominate economic life, the myth and the ideal of the entrepreneur have persisted — and not only in the daydreams of men on assembly lines who want a business of their own. Among economists, competition among numerous small firms remains the norm of analysts, from which all other conditions are distressing aberrations. In sociology, the independent practitioner is similarly the point of departure in the study of the professions. Bureaucratic professionals still seem anomalous even though they now represent the overwhelming majority of professionals in the modern world."

"In the twentieth century, medicine has been the heroic exception that sustained the waning tradition of independent professionalism. Physicians not only escaped from corporate and bureaucratic control in their own practices; they channeled the development of hospitals, health insurance, and other medical institutions into forms that did not intrude upon their autonomy. But the exception may now be brought into line with the governing rule."

"Unless there is a radical turnabout in economic conditions and American politics, the last decades of the twentieth century are likely to be a time of diminishing resources and autonomy for many physicians, voluntary hospitals, and medical schools. Two immediate circumstances cast a shadow over their future; the rapidly increasing supply of physicians and the continued search by government and employers for control over the growth of medical expenditures. These developments promise to create severe strains throughout the

The Social Transformation of American Medicine; Paul Starr, author; Basic Books, Inc., publisher; New York, 1982.

medical system. They may prepare the way, moreover, for the acceleration of a third development, the rise of corporate enterprise in health services, which is already having a profound impact on the ethos and politics of medical care as well as its institutions."

"Throughout Book One I have argued that sovereignty of the medical profession entailed the restriction of competition, the limiting of regulation by government or private organizations, and the authority to define and interpret the standards and the understandings that govern medical work. Emerging developments now jeopardize the profession's control of markets, organizations, and standards of judgment. The profession has benefited from state protection and political accomodation of its interests, but government is no longer so sympathetic and physicians are no longer the single, dominating claimant in the medical industry. The rise of the profession required internal cohesiveness and strong collective organization, yet rising internal pressures now threaten to drive a wedge between different segments of the medical profession. The prospect is not simply for the weakening of professional sovereignty, but for greater disunity, inequality, and conflict through the entire health system."

Mr. Starr is a Harvard sociologist whose book makes enlightening reading. One might argue with many bits of his bias and emphases, but the book published in 1982 (thus mostly written in 1980 and 1981) perceives with amazing accuracy the rapid development of government control of hospital expenditures, the corporate ownership of hospitals, the increasing competition, decreasing incomes, decreasing emphasis on private practice, and the subordination of the physician from his professional status to an employee status. The rise of corporate enterprise in health services may be the greatest danger to American health care yet. Are we fleeing from the grasp of "government medicine" into the arms of "corporate medicine" as Mr. Starr suggests? If we are, why does it matter? From Mr. Starr's point of view all of the small businesses and professions in our society have gone the corporate route. Medicine is the "heroic exception". It seems only a matter of time before it falls into line.

But, the preservation of our private practice system is crucial to doctor and patient alike. Now, the physician entering practice has a choice; he may enter private practice, become a full or part time hospital employee, work for an HMO or other corporate enterprise or a government agency. So long as the physician has the choice, the employer must grant the physician at least some of the independence of thought and action that he/she would enjoy in private practice. However, once the private practice option is eliminated, the physician is rapidly reduced to the status of an employee.

Now, the patient has the option of seeking medical care at a hospital, an HMO, or a private office. The HMO's and hospitals strive to treat him efficiently to be competitive in the private sector; but once the patient no longer has a private practice option the queues, months of delays, and favoritism so well known elsewhere will develop rapidly.

The corporate purveyors of health services seek to reduce costs by

employing midwives, optometrists, physician's assistants and the like; they thus dilute the medical services they offer and undermine the status of the physician by listing these persons with markedly restricted qualifications and licenses as equals to fully qualified and licenses physicians under the guise of "cost effectiveness" and "marketing", in the process, reducing the physician from his professional status to the status of employee. Mr. Starr points out that the "rise of the profession required internal cohesiveness and strong collective organization, yet rising pressures now threaten to drive a wedge between different segments of the medical profession." Well put. The "town and gown" fights and the tendency of some physicians to look with suspicion upon those physicians working for an HMO, hospital, or other corporate enterprises are ready examples of the wedges at work. Physicians of all kinds, regardless of their financial relationship with their patient must recognize that the maintenance of a viable private practice option is necessary for the maintenance of the professional status of all. Physicians in private practice must recognize that they are not threatened by the physicians in the HMO's or in a hospital practice, but that they are threatened by the corporate managers that would blur the distinctions between such physicians and technical employees. Let us recognize the wedge(s) for what it is. We must forget who signs our paychecks, and unite to retain the "internal cohesiveness and strong collective organization" that has made American medicine premier in the first place.

Your AMA and MMS are well aware of the importance of overcoming these devisive factors. It is important for the future of the whole American medical system that we all join together under their collective umbrella. After a decade of diminishing interest in medical organization, the pendulum has obviously swung towards their favor. But, a more rapid acceleration of this trend is important at this time to counteract the wedges that tend to divide us. □

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Visiting Nurse Association of Springfield

Establishes Alzheimer's Disease and Related Disorders Support Program

Alzheimer's Disease is a little-known but surprisingly common disorder that affects the cells of the brain. It is a disease that produces intellectual impairment in 500,000 to 1.5 million American adults. While experts formerly believed that Alzheimer's Disease occurred most often in persons under age 65, this disorder is now recognized as the most common cause of severe intellectual impairment in older individuals.

The Visiting Nurse Association of Springfield has begun to address the need on a local level. In June of 1983 the Agency sponsored the first in a series of educational sessions for families and friends interested in learning more about Alzheimer's Disease and its impact on family life.

Seven separate sessions were offered ranging in topics from medical management to legal issues. The program was very well attended and stimulated the Visting Nurse Association's Board of Directors to direct the management staff to repeat the series and develop any other services that might be necessary to assist patient/family units coping with this disease.

A peer support group has been established by the Visiting Nurse Association. Sessions are held on the second and fourth Thursday of each month from 1 to 3 p.m. at the Visiting Nurse Association headquarters, 600 Berkshire Avenue. Any interested family member or friend residing in greater Springfield may attend.

A second series of seven educational sessions is underway with plans for repeating the sessions in early spring.

The Visiting Nurse Association sponsored an all-day symposium on Alzheimer's Disease and Related Disorders in November. The symposium was open to professional and lay people with more than 200 persons attending. A follow-up symposium is now being planned for April.

Federal and state funds are being sought by the Visiting Nurse Association to establish the full-time position of Coordinator of Alzheimer's Disease and Related Disorders within the Visiting Nurse Association structure. One of the primary foci of this role will be to recruit and train volunteers who will offer respite to families caring for patients with Alzheimer's Disease. This program will be modeled after the very successful hospice-related Voluntary Care Giver service.

The Visiting Nurse Association of Springfield is sincerely interested in helping patients and families cope with the devastation of Alzheimer's Disease. Please call us 781-5070 if you have patients who might benefit from our services. □

MAUREEN SKIPPER, R.N., M.B.A.
Executive Director

Worker's Compensation — The First Week

No one is happy with our Massachusetts Workers' Compensation system! That was one of the conclusions of the conference sponsored by the Greater Springfield Healthcare Coalition October 25, 1983. Physicians, business leaders, labor representatives and insurance people met to discuss problems and heard some hints on solving some of them at the 3-hour CME approved session.

Dr. Garry deN. Hough presented the physician's overview printed elsewhere in this issue, noting well the need for all parties to communicate and work together, especially in the legislative field. Business representatives presented the need for better communication among hospitals, physicians, and the employees. Drs. John Prybylo and Thomas J. O'Neill spoke about the Occupational Health Physician and emergency physician's part of the picture. Attorney Charles Brids brought out the legal aspects as well.

The Massachusetts Medical Society's Director of Government Relations, Neil J. Foley, commented on the legislative process and felt that the need existed for a complete revamping of Workers' Comp legislation — much the same way the Chapter 327 was formulated for hospital cost containment — by a broad based coalition of business, medicine and insurance companies.

The proposed legislation to separate Workers' Compensation fees from the Medicaid scale set by the State Rate Setting Commission was passed by the House of Representatives in December, but failed again to get a hearing in the Senate, suffering a 1983 death. It will no doubt be refiled in 1984.

In the meantime, as was well noted at the meeting, physicians are increasingly reluctant to treat Workers' Comp. cases while employers and employees are becoming frustrated in getting treatment and efficient planning for return-to-work. □

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Worker's Compensation — The Physician's Report

I would like to begin by saying a few "thank yous." I would like to thank all of you for coming. Your presence shows that you agree with me that, in the words of Massachusetts courts in 1914, it is the duty of an employer "to furnish to an injured employee adequate and reasonable medical and hospital care." You also agree with me that the 80 year old system that promotes this care needs improvement. I would like to thank the business community for responding to the overtures of the Hampden District Medical Society in organizing the Greater Springfield Health Care Coalition, our sponsors this afternoon. I would like to thank the other speakers for their efforts to improve the care of the injured workers who are my patients. And I would like to thank Greater Springfield, my lifetime home, for being the kind of community where this type of dialogue can occur.

Now, having established myself as a nice guy, I want to spend the rest of my ten minutes telling you what's wrong with Workmen's Compensation. The doctors here already know this, so I am talking to the non-physicians in the audience. I am an orthopedic surgeon. I care for patients with injuries and disease of the bones and joints from a variety of sources. Workmen's Compensation patients are probably the least satisfying group that I deal with. I want my patients to get well. Most Workmen's Compensation patients are in no hurry to get well. I want my patients to utilize their abilities. All the insurance companies want to hear about is their disabilities. I want my patients to increase their activities gradually and steadily as they improve. Too many employers and union contracts demand that they make piece work rates as soon as they return to their employment. I want to spend my time taking care of the sick. My Comp patients need reports to employers, insurers, and all too often, attorneys. All in all, I don't like Compensation cases.

In addition to helping sick patients, doctors are motivated by a desire to advance the science of medicine. Those of us in private practice do this by reviewing our cases to see which procedures work well and which give less consistent results. Workmen's Compensation cases cannot be used for this purpose. The social factors preventing their recovering are so powerful that the patients are routinely excluded from studies made to determine the effectiveness of medical care.

Compensation patients become aware very rapidly of their legal rights and usually assume an adversary position against their employer. They often acquire a lawyer to promote this adversary relationship. Although the treating physician is usually perceived as being on the patient's "side," efforts to encourage return to work can shift this perception. With the patient already being litigation-minded, the risk of malpractice suits against the physician is higher in these patients.

In dealing with employers I find a great discrepancy in their apparent willingness to cooperate with a rehabilitation program. I have no trouble with the provision of medical treatment. Surgery, therapy, appliances, and consultations are accepted readily. Some companies will bend over backwards to provide job opportunities within the patient's physical capabilities. Some employers apparently don't have much light work available. Some can't make light work available due to union regulations or company policy. Some employers accept a patient back for light work, but foremen or other supervisors fail to honor the work conditions agreed upon. I don't treat enough compensation patients to know the characteristics of all the employers in town. When I try to contact an employer, I don't know who to talk to at most companies, so I am forced to rely on the patient's statements about employment conditions, an obviously biased source. The best system I have dealt with was many years ago when I saw a lot of Monsanto patients. Dr. William Nessell would call be personally to inquire about the medical condition of every lost-time accident victim. He would personally function as an ombudsman to get the patient back to work as soon as possible. It was a pleasure to cooperate with him.

I would be derelict in my duty to my fellow physicians if I did not mention fees. In the past two years, a regulation has been enforced in Massachusetts that pays physicians welfare rates for Workmen's Compensation patients. It is immaterial to this seminar that each Medicaid patient I see costs me money. Since I am old enough to remember

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treating the poor at no charge, I am not too upset by this. Only 15% of my practice is Medicaid and I can afford this much charity. But the injured worker, with all his added needs, deserves something better. Workmen's Compensation rates do not belong in the Massachusetts Rate Setting Commission.

My final complaint in more philosophical. One of my patients who is capable of gifted generalizations has observed that one of the greatest misfortunes which can befall an American these days is to have an accident that is someone else's fault. He immediately creates a vested interest in emphasizing his suffering, prolonging his disability, and litigating maximum financial advantage. Too many people believe that any industrial accident is the employer's fault.

In summary, the care of Workmen's Compensation patients is distasteful to the physician because:

(1) The patient has a vested interest in delaying his recovery.
(2) The employer is unpredictable in his desire and ability to facilitate the patient's return to work.
(3) Third parties require more extensive documentation than with other types of patients.
(4) The patients are too litigious.
(5) The compensation to the physician is inadequate for the service rendered.

I wish the subsequent speakers could solve all these problems. The very fact that employer representatives and physicians are talking with each other today can make a start on some solutions. Working together, we can improve initial patient-physician-employer contacts during the critical first week following injury. We can improve rehabilitation opportunities. We can minimize adversary confrontations. But we will also work together to bring about legislative changes or the system will deteriorate even further. Will we accept the challenge? □

GARRY deN. HOUGH, III, M.D.

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Wellness Seminar

The Greater Springfield Health Care Coalition and Springfield College conducted an Employee Wellness Seminar on November 10, 1983 at the Marriott Hotel in Springfield, MA. In attendance at this day-long event were approximately 150 persons.

The purpose of the seminar was to educate the representatives of local industry to the possibility of reducing health care costs. The program offered a wide variety of speakers and subjects with a primary focus on how wellness relates to cost containment efforts in employee benefits plans. Certainly, one of the highlights of this program was an informative, as well as interesting, keynote address by the nationally-recognized medical director of the Framingham Heart Study, William P. Castelli, M.D. Jan Ozga of the U.S. Chamber of Commerce, was the luncheon speaker; he focused on the U.S. Chamber of Commerce attempts to help industry to find out where their health care costs can be reduced.

Other speakers and seminar leaders included James E. Bernstein, M.D. (general health), William A. Yorzyk, M.D. who spoke on the Wellness Program at Massachusetts Mutual, and Ronald F. Sorenson, M.D. a new Director of Employee Health at Pratt and Whitney. The program concluded with Kurt Wilbur PhD. discussing the very complex and complete Wellness Program being run for Johnson & Johnson employees and Gerald D. Shulman of The Multiplex Group who described the successes of rehabilitating employees who have experienced drug and alcohol dependence problems. □

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Dr. Gerson is Assistant Professor of Pathology at Harvard Medical School and he is Director of Clinical Chemistry and Diagnostic Immunology in the Department of Pathology at the New England Deaconess Hospital in Boston, MA.

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Notes and Quotes of Interest

Enzo V. DiGiacomo, M.D., Vice President of Medical Affairs at Mercy Hospital will be a key speaker at the 27th Congress on Administration which will aid administrators to plot new corporate strategies among growing financial pressures and competition.

Stephen J. Levine, M.D., announces the opening of his new office at the Catherine Horan Medical Building Building, 1221 Main Street, Suite 302, Holyoke, MA. He will provide comprehensive medical care for adults, children and infants.

Ronald K. Burke, M.D., area gynecologist and credentialed in gynecologic microsurgery and pelvic laser surgery, has announced the formation of Fertility Associates of Western Massachusetts. Doctor Burke will be joined by Dr. Paul Shore-Suslowitz, licensed clinical psychologist, who will provide infertility and couples evaluation and counseling, and Shirley LaBorde, R.N.C., a certified gynecologic nurse practitioner who will serve as case manager coordinator. The professional staff of Fertility Associates will be capable of providing psychological, medical, surgical and microsurgical treatment of infertility.

Richard J. Miller, M.D., has relocated his office to 125 Liberty Street in Springfield, Suite 305. He practices plastic and reconstructive surgery.

J. Gordon Rich, M.D., and **Leonard Wagner, M.D.,** have moved their office for the practice of orthopedic and hand surgery to 401 Chesnut Street, in Springfield.

John S. Wojcik, P.A., a certified licensed physician's assistant is currently available for employment in this area. He can be reached for further information by writing to him at 21 Yale Street, Chicopee, 01020, or calling 594-2938.

*The *Hippocrat* will publish notices of interest to area health professionals in this column as space allows. Please send information to *The Hampden Hippocrat*, c/o HDMS, 1414 State Street, Springfield, MA 01109. □

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Hospital Medical Staff Sections

I would like to call your attention to an opportunity for physicians to improve the deteriorating environment of the practice of medicine. This opportunity has been created by the decision of the AMA to solicit input from hospital medical staffs. It is obvious that the practice of medicine is becoming more hospital oriented. It is also true that hospital oriented physicians have been under represented in organized medicine. The AMA House of Delegates has developed a Hospital Medical Staff Section which has held two meetings under the chairmanship of Dr. Tom Pebbles of Boston. When the several hundred delegates attending these meetings learn to use the political process of the AMA they will have significant influence on AMA policy.

Just as the AMA needs our input, so do we who work in hospitals need to understand national trends creating problems for physicians. Excellent seminars were arranged for this purpose at the December HMS section meeting. Paul Ellwood of Interstudy Inc. emphasised the need for physician consensus at all levels to keep us from being overwhelmed by the entrepreneurs responding to the economics of health care. The Hospital Medical Staff Section provides the opportunity for reaching such consensus and acting on it.

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Not all of us may want to spend the time and money to attend these national meetings, but every Massachusetts hospital staff should participate in the state HMS section. Our own unique approach to controlling costs, Chapter 372, may or may not be better than the national DRG program. Some groups claim that Massachusetts hospitals are receiving more federal Medicare money under Chapter 372 than they would under DRG. There is no question that the fate of this experiment depends on the cooperation of hospital administrators and physicians. This cooperation should be centered on the hospital medical staff structure. Administrators are coordinating through the Massachusetts Hospital Association. Physicians need a similar mechanism. Your medical staff president has been asked to appoint a delegate to the MMS-HMS section. After July 1, 1984 this delegate must be elected by the staff. Each of us should make sure that our hospital sends a delegate.

The mechanism of delivery of medical care is changing rapidly. Physicians have a choice of being people who make things happen or being people who wondered what happened. Our activities in Massachusetts may have national effects. We can continue to exercise the independent judgement at which we are skilled or we can devote our leadership abilities to developing a basis for collective action. Independence will help us adapt to the increasing restrictions placed upon us by administrators, legislators and bureaucrats. Collective action will give us a chance to shape the changes occurring in the delivery of health care. We must participate if we expect to deliver the kind of medical care that we know patients need and want. Get your medical staff involved! □

GARRY deN HOUGH, III, M.D.
Contributing Editor

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IN MEMORIAM

Francis Teta, M.D. died this past November 20, 1983 after being a member of the MMS for over 55 years.

Dr. Teta was born in New York City, did his premedical work at Columbia University and attended Albany Medical School and Middlesex Medical School, graduating in 1926.

He practiced as a general practitioner in the Springfield area until his retirement in 1978.

In Memory of Dr. Francis Teta

Condolences

("The body is a discarded garment of the soul")
("To live in the hearts we leave behind is not to die")
("Only he who leaves no inheritance of affection has little joy in the tomb")

Dr. Teta's death is bad news!
We've lost from this world a good soul
Whose kindness, true deeds and life's views
Are left on a spiritual scroll.

It's hard, yes to have such a blow,
But God has for us certain plans
That we cannot see, cannot know
And futile are protests or bans.

It's grief, extreme grief that unites
Thoughts, feelings and hearts in one tie.
It's fate — common fate — which ignites
Our hope to unite when we die.

To die is the end of our pain,
A voyage mysterious with ease
That we all will take in the train
Which carries our faith toward peace.

Our death can do only one thing:
Can transform our body into dust
Which nothing in spirit can bring
And nothing can hold in real trust.

And death is not truly the end Of all which belongs to the mind:
Name, memories, love, and — what's grand
The spirit which hovers behind.

Yes, death is a passage, a pause
For all of us beings to change "clothes"
The flesh — as in Nature's firm clause
Is shed like the petals of roses.

O mourners, we are here today,
Tomorrow no more on this earth.
What value have tears, our dismay
When death is expected from birth?

Courage and faith are for us all!
In time we will have the sure nod
To join our dear ones, for the call
Will certainly come from our God

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Welcome New Members

Leigh D. Ford, M.D.
759 Chestnut St.
Springfield, MA 01107

RESIDENT

BORN:	October 1, 1955
PREMED:	St. Lawrence University, Canton, NY 1972-76
MEDICAL:	NY Medical College 1977-82
INTERNSHIP:	Michigan State University Associate Hospitals 1982-83
RESIDENCY:	Baystate Medical Center-present

John J. Greco, M.D.
Shriner Hospital
516 Carew St.
Springfield, MA 01104

BORN:	November 4, 1954
PREMED:	University of Scranton, PA 1973-76
MEDICAL:	Temple University 1976-80
INTERNSHIP:	Presbyterian Hospital 1980-81
RESIDENCY:	Boston University 1981-present
SPECIALTY:	ORTHOPEDICS

Lee R. Pennington, M.D.
163 Silver St.
Agawam, MA 01001

BORN:	July 16, 1951
PREMED:	Montgomery College 1969-71 Duke University 1971-73
MEDICAL:	University of Maryland 1973-77
INTERNSHIP:	University of Maryland 1977-78
RESIDENCY:	University of Maryland 1978-80
SPECIALTY:	INTERNAL MEDICINE

Dennis R. Pannullo, M.D.
444 Montgomery St.
Chicopee, MA 01020

BORN:	January 22, 1952
PREMED:	Kenyon College, Ohio 1970-74
MEDICAL:	University de Guadalahara 1975-78 University of Nebraska 1978-80
INTERNSHIP:	U. Mass. Medical Center 1980-81
RESIDENCY:	U. Mass. Medical Center 1981-83
SPECIALTY:	INTERNAL MEDICINE

Jeffrey M. Komisar, M.D.
575 Beech St.
Holyoke, MA 01040

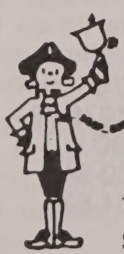
BORN:	February 12, 1950
PREMED:	University of Colorado 1968-70, University of Wisconsin 1970-72
MEDICAL:	Medical College of Wisconsin 1972-76
INTERNSHIP:	Long Island Jewish-Hillside Medical Center 1976-77
RESIDENCY:	University of Vermont-Medical Center Hospital, Vermont
SPECIALTY:	PATHOLOGY

John G. Tinervia, M.D.
759 Chestnut St.
Springfield, MA 01107

BORN:	January 8, 1951
PREMED:	LeMoyne College 1969-73
MEDICAL:	Autonomous University of Guadalajara 1973-77 5th Pathway thru Upstate Medical 1977-78
INTERNSHIP:	St. Joseph Hospital Syracuse, NY 1978-79
RESIDENCY:	St. Joseph Hospital Syracuse, NY 1979-81
SPECIALTY:	ANESTHESIOLOGIST

Gail L. Dickinson

BORN:	December 12, 1949
SCHOOL:	University of Massachusetts 1983-present
STUDENT:	



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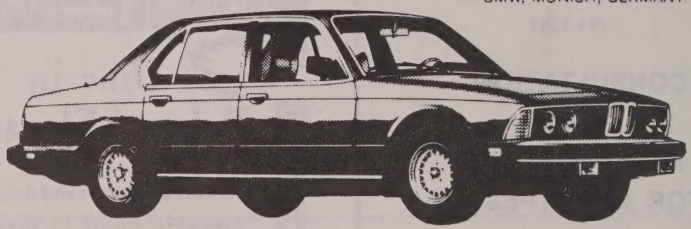

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